Advancing Partnerships Across Harm Reduction and Recovery

Resources, Recommendations, and a Report for the Field

SAMHSA
Substance Abuse and Mental Health Services Administration

Advancing Partnerships Across Harm Reduction and Recovery: Resources, Recommendations, and a Report for the Field

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Introduction

On June 6 and 7, 2024, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Office of Recovery, in collaboration with SAMHSA's Center for Substance Abuse Prevention's (CSAP) Office of Prevention Innovation (OPI), hosted *Exploring the Intersection—Summit on Harm Reduction and Recovery* at the Grand Hyatt in Denver, Colorado. This hybrid convening included over 75 in-person and 30 virtual participants with invaluable professional, lived, and living expertise with substance use and mental health issues. This group of professionals comprised a diverse array of identities, roles, and organizations—including representatives from recovery community organizations (RCOs), community-based harm reduction programs (CHRPs), national and state advocacy groups, and other local, state, and federal agencies working to prevent overdose, improve well-being, and advance harm reduction and recovery across the nation. The findings from the convening, along with a synthesis of other trusted, key federal resources (cited directly in hyperlinks throughout this document, as appropriate), serve as this document's foundation. *Advancing Partnerships Across Harm Reduction and Recovery—Resources, Recommendations, and a Report for the Field* is a document that:

- **Offers critical analysis** across the scope, focus, approaches, processes, services, organizations, pathways, and principles that guide harm reduction and recovery.
- **Outlines facts and guidance** for bridging the principles, values, and approaches of harm reduction and recovery.
- **Recommends strategies** for cultivating partnerships among providers and organizations working to provide or support harm reduction and/or recovery services.

Statement of Need

The staggering number of drug- and alcohol-related deaths across the country have had tragic impacts for individuals, families, and communities. In 2023, an estimated 106,875 lives were lost due to drug overdose. The Centers for Disease Control and Prevention (CDC) Alcohol-Related Disease Impact Application estimates that more than 178,000 alcohol-related mortalities occur every year. *SAMHSA's Summit on Harm Reduction and Recovery* was convened to facilitate coordinated and strategic partnerships among those leading response efforts to the crisis.

The Summit centered the professional expertise and lived/living experience of harm reduction and recovery experts from across the nation, providing a glimpse into innovations mitigating the devastating effects of the crisis and the resiliency of impacted communities. Over the course of two days, many technical experts expressed frustration, anger, and grief from losing loved ones to a preventable cause within systems that in their view were failing their communities.

Silos are systems, organizations, or sectors that work in isolation from each other. These present challenges that transcend disciplines, and substance use and mental health response efforts are no exception. Silos arise for many reasons and may stem from funding or policy limitations. Despite their similar lived and living experiences, shared grief and loss, and a common passion, misunderstandings across the harm reduction and recovery communities may also contribute to silos. Intended and unintended co-opting of these movements, due to mission creep or seeking funding opportunities, can strain an already limited funding pool and cause further frustration. This results in fragmented care, where people seeking help must navigate a disconnected continuum to access the full range of services they may need.

This document was also developed to inform policies that may impact local, state, and federal funding opportunities required to advance recovery and harm reduction across the nation.

Harm reduction strategies have been shown to prevent overdose, promote community well-being, enhance health and safety, reduce the risk of HIV and hepatitis infection, and increase the initiation of healthcare services—including substance use disorder (SUD) treatment where needed and wanted—among people who use drugs (PWUD). Similarly, recovery support services (RSS) such as peer support reduce challenges and improve relationships with social support systems for people with substance use or mental health conditions. Despite the evidence demonstrating their value, support for both have lagged when compared to other service areas across the continuum of care, such as SUD treatment.

Though certain services have been funded or supported since 2016, formal federal support for and recognition of harm reduction began in 2021 with the advent of efforts such as SAMHSA's Harm Reduction Grant and Harm Reduction Framework, nearly 40 years after the birth of harm reduction in the United States. Harm reduction and recovery support services are also frequently unfunded or underfunded in many states, territories, tribes, and local jurisdictions.

Harm reduction and recovery support services are evidence-based, data-driven solutions that are often hindered by a lack of funding, antiquated laws, medicalization, discrimination, and misunderstanding among service providers and the public. This document was developed and compiled to strengthen the foundational understanding of the approaches, services, pathways, and principles of harm reduction and recovery—and to serve as a steppingstone towards stronger partnerships across communities.

Background

SAMHSA's work to advance recovery support began with the establishment of the Community Support Program in the 1970s and subsequent funding for the Statewide Consumer Network Program, Statewide Family Network Program, and Recovery Community Services Programs (RCSP) in the 1980s and 1990s. SAMHSA has since worked to advance recovery across the nation through a myriad of efforts ranging from innovative recovery-oriented grant programs like Building Communities of Recovery, to the establishment of recovery training and technical assistance (TTA) programs, including Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS-TACS), SAMHSA Programs to Advance Recovery Knowledge (SPARK), and the Center for Addiction Recovery Support (CARS).

SAMHSA established the Office of Recovery (OR) in 2021 to advance recovery across the nation through policy and practice improvement efforts. That same year, SAMHSA established OPI within CSAP to lead harm reduction efforts and provide interagency expertise. SAMHSA subsequently announced an unprecedented $30 million harm reduction grant funding opportunity—the first and only federal grant with dedicated resources for community based activities. These advancements came on the heels of the U.S. Department of Health and Human Services' (HHS) Overdose Prevention Strategy (OPS), which outlined harm reduction and recovery support as two of the four pillars essential to our nation's response to the overdose and addiction crisis.

The U.S Department of Justice's (DOJ) Bureau of Justice Assistance (BJA) also supports harm reduction funding through the Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP). COSSUP funds may be used to support comprehensive syringe service programs (SSPs) that include education, training, screening, assessment, referrals to services, implementation support, and other harm reduction strategies such as fentanyl and xylazine test strips.

In April 2022, the Office of National Drug Control Policy (ONDCP) released the 2022 National Drug Control Strategy which outlines the advancement and expansion of evidence-based harm reduction and recovery support services as strategic priorities. ONDCP has since released the 2024 National Drug Control Strategy, which outlines further plans for expanding access to evidence-based harm reduction strategies and building a recovery-ready nation. In 2023, the U.S Food and Drug Administration (FDA) removed the prescription-only status of naloxone nasal spray, making it an over-the-counter medication. Prior to this change, the availability of and legality associated with the distribution of naloxone was dependent on state laws and regulations.

The criminalization of other vital overdose prevention and harm reduction supplies continues to present challenges. For instance, drug-checking equipment, which tests for adulterants such as fentanyl, is illegal in many states, despite a 2021 policy change that allows the use of federal grant funds for their purchase and distribution. Harm reduction providers also face challenges due to federal, state, and local policies. Harms associated with drug use, along with their disproportionate impact on Black, Indigenous, and People of Color often merge with chronic underfunding to perpetuate existing challenges in many communities.

> *"The field itself and harm reduction practice emerged decades ago, as direct community action and mutual aid in response to effects of the "War on Drugs," an early and incomplete scientific understanding of substance use and substance use disorders, and government inaction to swiftly respond to the growing HIV/AIDS epidemic."*
>
> — **SAMHSA's Harm Reduction Framework**

Similarities and Differences Across Harm Reduction and Recovery

Both harm reduction and recovery response efforts are vital to community health and well-being. Their distinct but complementary strategies help people take self-directed action to improve their lives. At its core, harm reduction empowers PWUD and their families with the choice to live healthier, self-directed, and purpose-filled lives. Similarly, recovery supports promote a process of change—specifically mitigating challenges related to substance use, mental health, and co-occurring conditions through which individuals and families improve their health and wellness, live a self-directed life, and strive to reach their full potential. Understanding these approaches as intertwined rather than separate enables a more holistic and effective response to the complex needs of those seeking support.

We highly encourage readers to familiarize themselves with the definitions, FAQs, and Fast Facts presented in Appendixes B, C, and D before reading the following sections.

Focus and Scope

Harm reduction and recovery both play important roles in community care. As noted in Appendix A—Scope & Focus of Harm Reduction and Recovery, harm reduction encompasses a set of services and approaches that improve the safety and well-being of PWUD—including those who may or may not need, require, or desire recovery support services or treatment. Harm reduction strategies and techniques are important to those who are at higher risk of overdose and other harms associated with substance use but may not meet the criteria for a SUD or be engaged in chaotic substance use, including people experimenting with drugs and alcohol and casual or social drug users.

Harm reduction as a movement and philosophy is framed around the empowerment of PWUD and their (chosen) families, whereas peer recovery support is framed around the empowerment of people who are in or may be seeking recovery from challenges associated with a mental health and/or substance use condition. Harm reduction services (HRS) and strategies are interconnected with whole-person health and can reduce risks associated with mental health conditions and a myriad of other health/public health issues.

Harm reduction strategies can also be used to support people who drink alcohol, regardless of whether they may or may not have an alcohol use disorder (AUD). Alcohol is defined as a drug by scientists and policy makers, and the full continuum of care is vital for those who are in recovery from or may be seeking support for their AUD. As such, all references to drug use and the services, organizations, principles, and approaches that mitigate related harms are also inclusive of harms stemming from alcohol use.

Principles

During *SAMHSA's Summit on Harm Reduction and Recovery,* technical experts identified core principles that guide their recovery, harm reduction, and/or intersectional work. The most common principles were:

Dignity and Respect

Recovery and harm reduction restore dignity and respect all people as the experts in their own lives.

Journey and Process

Recovery and harm reduction reflect the diverse and individualized nature of journeys to wellness.

Person-Centered Approach

Recovery and harm reduction are tailored to the individual's unique circumstances and needs, respecting their personal goals and desires.

Lived and Living Experience

Recovery and harm reduction center lived and living experience in their work.

Change

Recovery and harm reduction focus on positive change.

Compassion and Acceptance

Recovery and harm reduction depend on compassion, acceptance, and unconditional support, emphasizing the need for an environment that nurtures and accepts individuals and fosters a sense of belonging and acceptance.

Figure 1 compares the values and support/guiding principles listed in the *SAMHSA Harm Reduction Framework* and *SAMHSA's Working Definition of Recovery.* This demonstrates many existing points of alignment across the harm reduction and recovery fields.

Figure 1. *Aligned Values of Harm Reduction and Recovery*

Recovery

- **Recovery** is holistic and occurs via many pathways.
- **Recovery** is supported by peers and allies, and through relationships and social networks.
- **Recovery** is based on respect, is person driven, and promotes a self-directed life.
- **Recovery** is culturally based and influenced and involves individual, family, and community strengths.

Harm Reduction

- **Harm reduction** provides many pathways to well-being and focuses on any positive change as defined by the person.
- **Harm reduction** is led by people with lived and living experience and cultivates relationships.
- **Harm reduction** practices acceptance and hospitality and respects autonomy.
- **Harm reduction** values practice-based evidence and on-the-ground experience and commits to deep community engagement and building.

Many Pathways

The term *many pathways* is a fundamental and guiding principle of both harm reduction and recovery. Though significant, advocates and professionals may use differing definitions or attribute a specific service, approach, or modality to define or describe a recovery pathway. Terms like "abstinence", '"harm reduction", or "12-Step"-based are often used to solely describe or define a person's recovery pathway, and medications for treatment of alcohol and opioid use disorder (OUD) are sometimes stigmatized. These oversimplifications may fail to account for the complexity of substance use and mental health needs and distort the personal nature of recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Many pathways within the harm reduction space also emphasize the importance of choice in a person's pathway to well-being. The following definitions clarify some of the misunderstandings associated with pathways in recovery spaces:

- A (person's) pathway **to** recovery describes a deeply personal accumulation of clinical and/or nonclinical tools, services, resources, supports, or strategies used to **begin** their recovery.
- A (person's) pathway **of** recovery describes a deeply personal accumulation of clinical and/or nonclinical tools, services, resources, supports, or strategies used to **sustain** their recovery.

These concepts are further illuminated using real-world examples from our partners in Figures 2 and 3.

Figure 2. *From the Field—Pathways to Recovery*

What tools, services, resources, or supports comprised your pathway to recovery?

Expert Partner #1: "My pathway to recovery included clinical detox, peer support, trauma-informed therapy, recovery housing, and medication management."

Expert Partner #2: "My pathway to recovery involved a syringe service program, several overdose reversals, recovery housing, and MOUD."

Figure 3. *From the Field—Pathways of Recovery*

What tools, services, resources, or supports currently comprise your pathway of recovery?

Expert Partner #1: "My pathway of recovery includes my 12-step network, an abstinence-based approach, nutrition, continuing (my) medication management and therapy, career, playing sports, and my family."

Expert Partner #2: "My pathway of recovery includes my harm reduction works network/community, career, pursuing a higher education, and harm reduction strategies I use to drink alcohol responsibly and safely in social situations."

Services and Supports

The practices and services that flow from RCOs and CHRPs are intrinsically tied to the autonomy of the individual on a self-directed journey and refrain from the use of shame-based approaches. RCOs and RSS focus on more than abstinence, emphasizing addressing social determinants of health and helping a person thrive.

Like harm reduction, recovery support is most effective in community-based settings but are intended for individuals and families seeking reprieve from challenges related to a substance use, mental health, or co-occurring condition. As noted in Figure 4, the services and support systems of harm reduction and recovery cater to distinct needs while sharing interconnected principles and outcomes that are vital to a person's well-being.

Figure 4. *Comparison of Services and Supports*

Distinct Needs

- Both cater to distinct but equally important needs.
- RSS provides support to people who are seeking and curious about a pathway to/of recovery while harm reduction caters to the needs of all PWUD within a community, no matter what support they desire/require.

Vital Outcomes

- Both promote wellness and save lives and are vital for helping individuals overcome challenges related to substance use and move towards a healthier, more self-directed life.

Interconnected Principles

- Despite their unique attributes, harm reduction and recovery are interconnected and share common principles that guide their work.
- Organizations have a shared responsibility to provide all PWUD with compassionate and choice-based care—whether through coordination/referrals between organizations or by integrating services if necessary.

Partnership and Integration

A 2018 study found promising benefits from a hybrid recovery community drop-in center/syringe service program. Many technical experts recognized similarities across their programs and the value of and need for additional collaboration, include advocacy efforts to increase funding for community-based work. RCOs, with their stronger access and connection to the traditional behavioral health system than harm reduction partners, can play a role in ensuring that CHRPs are routinely involved decision-making and help to reduce disinformation and discrimination.

However, there remains concern that integration could compromise the trust and authenticity of each (e.g., would harm reduction practices within a RCO put at risk a person's chosen abstinence journey, or could recovery-oriented services within a CHRP push away PWUD who aren't seeking recovery). These concerns can be addressed through collaboration between the leaders and providers within each community. Partnership and communication between harm reduction and recovery partners are essential for truly effective, authentic, and culturally responsive integration. Some potentially innovative and beneficial strategies identified during the summit include an "umbrella" approach with parallel tracks and mutual aid models of care and collaboration.

> *"Recovery is rooted in the value of lived and living experience… (and with) harm reduction's role in the psychiatric survivor movement, peer support is also a core component of harm reduction."*
>
> **—SAMHSA Expert Partner**

Various innovations are being used to promote access to a full continuum of services. CHRPs and RCOs alike are adapting to meet the needs of the communities they serve through integration of non-typical services or supports. Some examples that were identified by technical experts are outlined in Figure 5.

Figure 5. ***Integration of Services Across CHRPs and RCOs***

Integration of Harm Reduction within RCOs

Harm reduction principles and services are needed within many communities, and some RCOs have responded by beginning to integrate harm reduction beyond the dispensing of naloxone. This includes addressing social determinants of health, distributing sterile syringes, remaining engaged with an individual during a recurrence in their substance use, and respecting a self-directed journey. Some innovative practices identified include:

- Mobile units that provide syringe services, sexually transmitted infection testing, and other HRS.
- Family education on the importance of self-directed, noncoercive approaches.
- Addressing other social determinants.
- Coordinated referral networks with local CHRPs.

Integration of Recovery within CHRPs

CHRPs recognize and support recovery as a pathway to well-being, just not as the only pathway. CHRPs regularly integrate peer recovery support services into their offerings or refer clients to recovery support or treatment services when requested. Some innovative practices identified include:

- Hiring and training peers in recovery to provide both harm reduction and peer recovery support services.
- Offering education and linkages to RCOs, recovery housing, and other RSS.
- Developing recovery action plans with clients who request recovery services.

CHRPs and RCOs are distinctly community based. The incorporation and co-optation/appropriation of HRS and RSS into treatment and healthcare settings without the foundational principles that should guide both into treatment and healthcare settings has created challenges. Harm reduction and recovery communities have reported being impacted by these entities competing for limited funding opportunities, worsening outcomes for those served and giving rise to distrust and hesitancy within communities due to the lack of principles and limited lived/living experience within treatment organizations.

Additionally, this may inadvertently shape a CHRP's view of an RCO and vice versa. For example, a harm reduction expert at the Summit believed that RCOs were treatment centers, and that recovery was the same thing as clinical treatment. Co-optation is rooted in power and funding imbalances—and both the harm reduction and recovery communities can counteract this by enhancing communication and partnership with each other.

Recommendations

In partnership with technical experts, a set of recommendations were developed to strengthen both fields and the partnership and collaboration that occurs between them. These recommendations were developed by and are intended for those providing harm reduction and recovery support services and for those involved in the policies that may impact and fund them.

- **Partnerships Come First.** Funding is limited for both harm reduction and recovery, and local, state, and federal support for harm reduction is nonexistent in some areas. Thus, RCOs that are interested in applying for harm reduction-specific funding opportunities should seek out partnerships and collaborate with the harm reduction community before applying. Funders should also specify the need for such partnerships.
- **Amplify Local Efforts.** Sharing and elevating practice-based evidence of localized harm reduction and recovery support programs nationally would be impactful. This includes combined partnerships between RCOs/CHRPs and governmental entities.
- **Form and Announce Cross-Continuum Partnerships.** RCO and CHRP leadership should open lines of communication with and intentionally establish and announce formal partnerships where possible. Openly and publicly announcing formal partnerships would also demonstrate a more unified approach to saving lives despite the differing approaches and could potentially lead to other organizations following suit. Additionally, RCOs and CHRPs should utilize these partnerships for cross-continuum consultation.
- **Address Power and Funding Imbalances Together.** Create incentives to move more funding and power to community-based services. Some examples include building coalitions to advocate for the health and wellness of PWUD; getting RSS and HRS to be reimbursable; providing grant set-asides restricted to community-based entities; and incorporating living and lived voices in all discussions.
- **Address Harms.** Addressing harms from the crack epidemic/War on Drugs/HIV epidemic is necessary for moving forward. Historically marginalized communities (e.g., Black/African American, Latin/Latinx, Indigenous, LBGTQIA+ communities) have disproportionately been impacted, and lingering effects still exist from the harms caused by our nation's legal

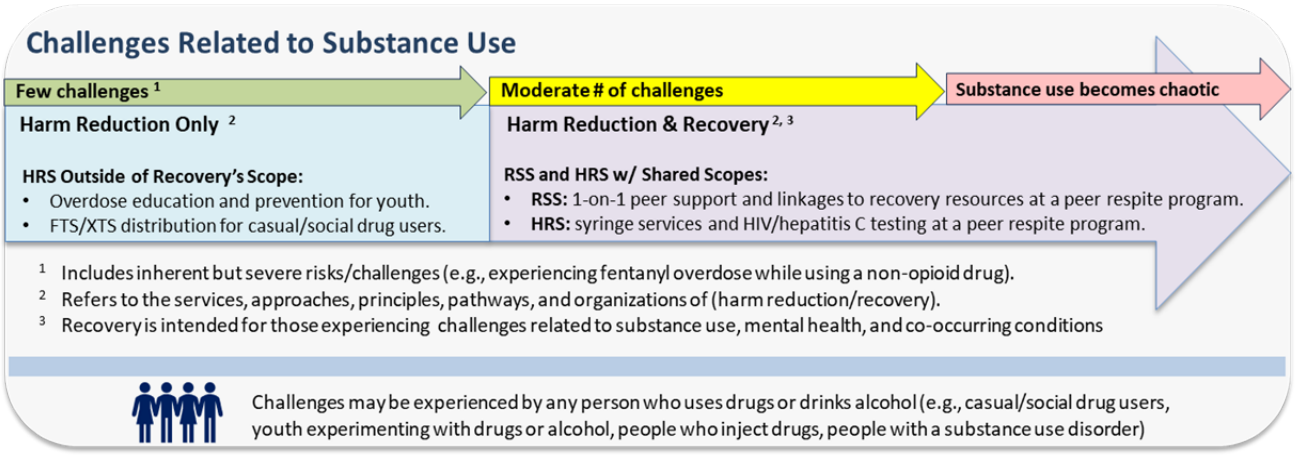
system and discriminatory practices within the system of care. Intentional efforts to include these communities in **decision-making and leadership** spaces is paramount.

- **Adopt Trauma-Centered Approaches.** Addressing trauma should be an underpinning of all recovery and harm reduction work and related policy-making decisions.
- **Improve Data Collection.** Community-based organizations do not have the resources to conduct studies to demonstrate evidence-based practices. Harm reduction participants need to be involved in and compensated for the planning and implementation of data efforts, including identifying measures that are representative of their work beyond measures like the number of individuals served who eventually received SUD treatment. Treatment is *not* the exclusive aim of harm reduction.
- **Recognize and Leverage Accessibility Differences.** Due to criminalization of SUD and other discriminatory experiences, people with living experience of drug use may not feel welcome in certain spaces across the continuum of care. Recognizing their value both personally and professionally will create a more inclusive and effective continuum. Consideration must also be made about the inclusion of law enforcement on advisory boards where people with lived and living experience are expected to participate.

Conclusion

Harm reduction and recovery are powerful strategies for addressing the complexities and challenges associated with substance use and mental health conditions. Both improve wellness through strategies that address social determinants of health to build and sustain a pathway of recovery and/or well-being. This document has outlined essential themes that define these interconnected fields while emphasizing the importance of collaboration and mutual respect among all partners. As the country continues to lose loved ones, neighbors, and colleagues, this importance becomes increasingly evident. By fostering open communication and shared understanding, carving out lanes, integrating innovative practices, and advocating for equitable funding and policy support for one another, the United States can create a more inclusive, responsive, and effective continuum of care. The recommendations provided above are designed to guide organizations, policymakers, and communities in their efforts to bridge gaps and build stronger, more resilient support systems. Through continued collaboration and a shared commitment to meeting people where they are, all individuals—regardless of their desired pathway to well-being or recovery—can have access to the resources and support they need to live healthier, purpose-filled, and more self-directed lives. The future of harm reduction and recovery lies in our collective ability to break down silos, challenge discrimination, create opportunities for people with lived and living experience in decision making, and work together toward a common goal: **saving lives and fostering well-being for all.**

Appendix A—Scope and Focus of Harm Reduction and Recovery



Please note that substance use is not a prerequisite for benefitting from harm reduction. People experiencing other challenges, such as mental health or homelessness, may benefit from harm reduction services, such as access to sterile syringes. A specific example of this could include unhoused people who have diabetes.

Appendix B—Key Definitions for the Field

The processes, pathways, principles, services, and organizations associated with harm reduction and recovery encompass similarities and differences that can be clearly defined but are sometimes impacted by complex qualities or subtle nuances. The following is a list of key terms and definitions have been synthesized from trusted federal resources for use by those leading our nation's peer recovery support and harm reduction efforts to better understand these complexities.

PROCESS AND APPROACH

1. **SAMHSA's Working Definition of Recovery**[1]
   A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Framing Recovery

"This definition does not describe recovery as an end state, but rather as a process. Complete symptom remission is neither a prerequisite of recovery nor a necessary outcome of the process. Recovery can have many pathways that may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches."

—SAMHSA's Bringing Recovery Supports to Scale Technical Assistance Center Strategy

2. **SAMHSA's Definition of Harm Reduction**[2]
   A practical and transformative approach that incorporates community-driven public health strategies—including prevention, risk reduction, and health promotion—to empower PWUD and their families with the choice to live healthier, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of PWUD, especially those in underserved communities, in these strategies and the practices that flow from them.

Framing Harm Reduction

"SAMHSA conceptualizes harm reduction as being a set of services, an approach, and a type of organization. Harm reduction has, at times, been reduced to a singular service or group of services, when in fact, its application goes well beyond this. Harm reduction as an approach—with supporting principles and pillars that can be applied to a variety of contexts—includes the provision of evidence-based treatment."

—SAMHSA's Harm Reduction Framework

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[1] SAMHSA's Working Definition of Recovery refers to recovery from both mental health and substance use conditions.

[2] As defined in SAMHSA's Harm Reduction Framework. Harm reduction is centered around people who use drugs (PWUD)—which may or may not include people who meet the criteria for a substance use, mental health, or co-occurring condition/diagnosis.

PATHWAYS

3. Many Pathways

A guiding principle of recovery that describes the recovery process as a highly personal accumulation of clinical and/or nonclinical tools, resources, support systems, and/or strategies. Many pathways (to wellness) is also a supporting principle of harm reduction, is characterized by continuous growth and improvement in one's health and wellness, and acknowledges that setbacks can be a natural part of life and/or the recovery process for some.

3a. Pathway to Recovery

A deeply personal accumulation of clinical and/or nonclinical tools, resources, support systems, and/or strategies that a person may use to begin their recovery from a substance use, mental health, or co-occurring condition.

3b. Pathway of Recovery

A deeply personal accumulation of clinical and/or nonclinical tools, resources, support systems, and/or strategies that a person may use to sustain their recovery from a substance use, mental health, or co-occurring condition.

PRINCIPLES

4. Dimensions and Principles of Recovery

SAMHSA's Working Definition of Recovery is supported by 4 core dimensions (aka pillars) and guided by 10 principles that give life to recovery processes, community-based organizations, and support services. To learn more about recovery and the dimensions, principles, and services outlined below, visit SAMHSA's Recovery and Recovery Support webpage.

Dimensions of Recovery

Health: Making informed, healthy choices that support physical and emotional well-being.

Home: A safe and stable place to live.

Purpose: Meaningful activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.

Community: Relationships and social networks that provide support, friendship, love, and hope.

Guiding Principles of Recovery

Recovery…

1. emerges from **HOPE**
2. is **PERSON-DRIVEN**
3. is **HOLISTIC**
4. occurs via **MANY PATHWAYS**
5. is supported by **PEERS** and allies
6. is supported through **RELATIONSHIPS**
7. is based in **CULTURE**
8. addresses **TRAUMA**
9. involves **STRENGTHS & RESPONSIBILITY**
10. is based on **RESPECT**

5. Pillars and Principles of Harm Reduction

SAMHSA's definition of harm reduction contains 6 pillars and 12 supporting principles that give life to harm reduction approaches, initiatives, programs, and services. Visit SAMHSA's *Harm Reduction Framework* to learn more about harm reduction and its accompanying pillars and principles.

Pillars of Harm Reduction

1. Led by **PWUD & WITH LIVED EXPERIENCE OF DRUG USE**
2. Embraces the **INHERENT VALUE OF PEOPLE**
3. Commits to deep **COMMUNITY ENGAGEMENT AND BUILDING**
4. Promotes **EQUITY, RIGHTS, & REPARATIVE SOCIAL JUSTICE**
5. Offers most **ACCESSIBLE AND NONCOERCIVE** support
6. Focuses on **ANY POSITIVE CHANGE,** as defined by the person

Supporting Principles of Harm Reduction

1. Respect **AUTONOMY**
2. Practice **ACCEPTANCE AND HOSPITALITY**
3. Provide **SUPPORT**
4. Connect with **COMMUNITY**
5. Provide **MANY PATHWAYS** to well-being
6. Value **PRACTICE-BASED EVIDENCE AND ON-THE-GROUND EXPERIENCE**
7. Cultivate **RELATIONSHIPS**
8. **ASSIST,** not direct
9. Promote **SAFETY**
10. **ENGAGE** first
11. Prioritize **LISTENING**
12. Work towards **SYSTEMS CHANGE**

SERVICES

6. **Recovery Support Services (RSS)**
   An array of nonclinical services and programs provided by professionals or peers with lived/living experience with a mental health, substance use, or co-occurring condition, which are tailored to assist people who are experiencing similar challenges.
   - RSS adhere to SAMHSA's 10 Guiding Principles of Recovery and SAMHSA's Core Competencies for Peer Workers; and are delivered through a variety of organization types such as RCOs, community and faith-based groups, treatment providers, CHRPs, and others. RSS are based upon the needs in a person's individualized recovery plan.
   - *Examples of RSS*—hosting peer support/mutual support groups or meetings; advocating for policy-related changes that remove barriers or reduce discrimination associated with substance use and recovery; offering individual or community naloxone distribution and overdose prevention education; providing a coordinated system of care that includes referrals to treatment, prevention, and HRS; collegiate recovery programs (CRPs).

7. **Core Practice Areas of Harm Reduction**
   The six core practice areas outlined in SAMHSA's *Harm Reduction Framework* guide the provision of HRS. These core practice areas are centered around education, support, access, connections, and/or resources that enhance access to/directly lead to:

   - **Safer Practices.** Education and support describing how to reduce risk; provision of risk reduction supplies and materials.
   - **Safer Settings.** Access to safe environments to live, find respite, practice safer use, and receive supports that are trauma-informed and stigma-free.
   - **Safer Access to Healthcare.** Ensuring access to person-centered and non-stigmatizing healthcare that is trauma informed, including FDA-approved medications.
   - **Safer Transitions to Care.** Connections and access to harm-reduction-informed and trauma-informed care and services.
   - **Sustainable Workforce and Field.** Resources for maintaining a skilled, well-supported, and appropriately managed workforce and for sustaining community-based programs.
   - **Sustainable Infrastructure.** Resources for building and maintaining a revitalized and community-led infrastructure to support harm reduction best practices and the needs of PWUD.

8. **Harm Reduction Services (HRS)**
   An array of clinical and nonclinical services and interventions that are led and provided by people with lived and living experience of drug use, and flow from the principles, pillars, and core practice areas of harm reduction noted in the Core Practice Areas of Harm Reduction above.
   - HRS may relate to any part of the continuum of care—including prevention, treatment, recovery support, and health promotion—and may be delivered by organizations, individual harm reductionists, or integrated into a comprehensive, person-centered program of care that meet the specific needs of the community in which the services are housed.

- *Examples of HRS*—distributing risk reduction supplies (e.g., syringes, safer smoking supplies, opioid overdose reversal medications like naloxone, fentanyl test strips) to community members who use drugs; syringe and clean-up services (e.g., picking up/disposing used syringes); low barrier buprenorphine induction; street-based counseling; referrals to treatment or recovery support services/organizations; viral hepatitis and HIV testing and treatment services; distributing other vital supplies, such as blankets, food, and water.

ORGANIZATIONS

9. Community-Based Harm Reduction Program (CHRP)

Organizations where people with lived and living experience lead the planning and oversight, program development and evaluation, and resource/funding allocation for harm reduction initiatives, programs, and services.

- CHRPs also offer the core practice areas noted above, as permitted by law. Harm reduction activities may be integrated into a comprehensive, person-centered program of care that includes treatment services that meet the specific needs of the community in which the program is housed.
- In addition to being consistent with all principles and pillars, CHRPs should include people with lived experience as co-investigators in any research project. Boards, staff, and team members should be at least 51 percent those with lived or living experience.

10. Recovery Community Organization (RCO)

Also known as *peer-operated services programs/organizations,* RCOs are independent, non-profit, grassroots organizations where people with lived and/or living experience lead the planning and oversight, program development and evaluation, and resource/funding allocation for activities such as recovery support services and initiatives; peer support; community engagement; and recovery advocacy.

- RCOs provide peer and community-based, person-centered support services that build on the strengths and resiliencies of individuals, families, and communities.
- RCOs also offer choice-based services that improve health, wellness, and quality of life for those with or at risk of challenges associated with a substance use and/or mental health condition.
- Although RCOs are inherently nonclinical, some organizations may provide certain clinical (non-RSS) services to meet the needs of their community.

OTHER KEY TERMS

11. Lived and Living Experience

Personal knowledge gained through direct, first-hand involvement in everyday events rather than through representations constructed by other people. In the context of this document, the following assumptions can be made when referring to people with lived and living experience:

Lived and living experience include direct experience with: (1) the social, health, public health, and other issues and challenges associated with substance use and/or mental health (including as a family member for family relevant services), and (2) strategies that aim to address associated challenges.[3]

[3] Strategies, services, and programs related to both harm reduction and/or recovery.

Lived experience implies a past connotation involving challenges related to substance use and/or mental health, with or without a diagnosis, and often encompasses people who identify as being in recovery or people who formerly used drugs.

Living experience implies a present connotation involving substance use and/or mental health, with or without a diagnosis, and includes people who currently use drugs.[4]

12. Peer support

The process of offering and receiving help based on shared understanding, respect, and mutual empowerment between people in similar situations.

13. Peer/Peer Specialist/Peer Worker

Interchangeable terms that describe a person with lived or living experience who supports other people experiencing similar challenges in a wide range of nonclinical activities including advocacy, navigation of and linkage to resources, sharing of experience, social support, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more. Peers often complete trainings, certifications, or other types of professional development related to their role/responsibilities and can be embedded across a variety of settings and organizations including RCOs, CHRPs, and more. Peers also often have different lived/living experiences, trainings, and roles/responsibilities depending on the setting, organization, and population they serve.[5] It is important to note that state and national peer certification entities often utilize differing terms and definitions to describe the peer role, and their certification process may limit the accessibility of or even exclude peers with living experience who have experience critical to effective harm reduction program design, implementation, and evaluation. In response, SAMHSA developed the National Model Standards for Peer Support Certification in 2022 to provide recommendations to the peer certification field.

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[4] Lived or living experience may include direct experience with a mental health condition when referencing recovery. However, lived or living experience in harm reduction settings for this report is based upon direct experience with substance use and its intersection with other identities and experiences (e.g., mental health, homelessness, legal system).

[5] For example, a CHRP may seek out and hire peers with living experience of drug use and require the completion of specific harm reduction trainings. Similarly, an RCO that offers peer services in their local jail may require lived experience with the criminal legal system and a substance use, mental health, or co-occurring condition, and may have requirements surrounding training and certification set forth by the state or jail in which the services are provided.

Appendix C—FAQs

- **Is harm reduction inclusive of abstinence-based approaches to/of recovery?** Yes! Harm reduction is supportive of abstinence when **chosen** as an approach by the person making the change. Many harm reduction program participants are referred to and walk through the doors of abstinence-based treatment when desired. Harm reduction is centered upon the principles of autonomy and choice and does not support any approaches, services, or pathways that are coerced.
- **Do CHRPs refer PWUD to treatment or recovery support programs?** Absolutely. Harm reduction respects each person's autonomy and choice, and CHRPs depend on partnerships with the treatment and recovery communities for referring clients, if requested. Some CHRPs include low-barrier buprenorphine treatment or mobile methadone as a part of their service provision through partnership or their own medical staff.
- **Can clinical, evidence-based treatment like MOUD be considered an RSS or HRS?** Although RSS are inherently nonclinical in nature, many RCOs integrate or provide clinical services based on the needs of their community and those they serve. On the other hand, evidence-based treatments can be considered HRS, and CHRPs often provide these services in a low-barrier fashion and consistent with harm reduction and recovery principles within their community.
- **Is harm reduction the opposite of recovery?** No. A common myth and stereotype is the assumption that harm reduction is defined as substance or illicit drug use and recovery is complete abstinence from all substances. Both harm reduction and recovery support strategies and services can be critical components of a person's pathway to/of recovery—including for some who may rely on an abstinence-based approach. It is also important to remember that SUDs are clinically complex and may involve relationships with one or multiple substances and include symptoms that range from mild to severe. Those complexities may translate into nuances and different approaches that are used.
- **Can a service be considered both an RSS and HRS? Can an organization be both a CHRP and RCO?** Guiding principles are critical in determining whether a service/organization is an RSS, HRS, RCO, or CHRP. The following outlines some important facts that can be used to differentiate between the services and organizations of harm reduction/recovery.

CHRPs and RCOs

- Overlap in the services that each provides may exist. Some CHRPs may integrate specific recovery support services such as group peer recovery meetings, peer mentoring, social activity/community building, or recovery resource connecting, whereas others may choose to refer clients out who request these services. Similarly, some RCOs may adopt harm reduction principles and services such as syringe services, overdose education and naloxone distribution (OEND), or HIV/hepatitis testing while others may refer out for these services.

- There is also no rule, certification, or policy preventing organizations from being considered both a RCO and CHRP.
- Whereas RCOs and CHRPs are both centered on the voices, expertise, and leadership of people with lived and living experience, CHRPs more greatly emphasize the inclusion of leadership and staff with living experience of drug use—including those who may not have a SUD.
- CHRPs have a broader scope and are founded upon the approaches, principles, and pillars of harm reduction; RCOs center on services for people that are in, seeking, or interested in learning more about recovery.

HRS and RSS

- HRS have a broader lens and are intended for all PWUD—regardless of whether they meet the criteria for a SUD, and irrespective of whether they are interested in recovery. Conversely, RSS are specifically intended and designed to meet the needs of people with a substance use and/or mental health condition that are in recovery or are interested in learning whether recovery is right for them.
- Core RSS services include 1-on-1 peer mentoring, recovery action planning, and recovery resource connecting (e.g., recovery housing programs), collegiate recovery programs.
- Core HRS services include syringe access services, safer drug use/ sex education, OEND, low-barrier shelter and housing referrals, and wound care.

Appendix D—Fast Facts

- **Parts of a Continuum.** Harm reduction, prevention, treatment, and recovery support are separate, vital components within the broader continuum of care. However, overlap, intersections, and integration can occur.
  - **People can use harm reduction strategies within their personal pathway of recovery—**but that doesn't mean that harm reduction and recovery are the same thing (or that harm reduction is their pathway of recovery).
  - **Some services share overlapping qualities or may (objectively) be perceived as an RSS and HRS.** However, the population of focus and the principles that guide the delivery of that service are equally important.
  - **RCOs and CHRPs are not treatment centers,** but some RCOs and CHRPs may provide certain clinical services to meet the needs of their community.
  - **RSS are inherently nonclinical, whereas some HRS can include clinical treatment.** Clinical treatment services, such as low barrier buprenorphine induction and hepatitis/HIV treatment, are crucial HRS. Clinical services can also be important parts of a person's pathway to/of recovery or well-being and may sometimes be embedded as (non-RSS) services within an RCO.
- **The Foundation of Peer Support.** Peer support is founded upon lived and living experience and vital for the provision of harm reduction and recovery alike. It is important to acknowledge and respect the value of peers with living experience and the crucial role they play in our nation's response efforts. Similarly, some programs, peers, and people they serve, may require abstinence-based approaches that require environments that are substance-free.
- **Peers are Experts.** Although lived and living experiences are the foundation on which peer support is built, peers working in both harm reduction and recovery support settings are experts in their field. Peers often complete trainings, certifications, and other forms of professional development related to recovery and/or harm reduction to ensure they are providing quality services. Thus, harm reduction and recovery peers are professionals and experts, too. Peers should also be involved at the decision-making level, including the design, implementation, and evaluation of programs, as this is evidenced to lead to better outcomes.
- **Scope and People.** The scope of harm reduction involves empowering all PWUD. This may include people with or without a SUD, as well as those who may have a SUD but aren't seeking or desire recovery. Recovery support is specifically intended for people and families who are seeking recovery (as a service or pathway) to mitigate the negative impacts and challenges stemming from their condition.
- **Mental Health Needs.** Recovery support services and organizations may solely focus on people who are seeking reprieve from challenges related to a mental health condition. Conversely, harm reduction's impact on and relationship to mental health is predicated upon its whole-health approach to reducing

the harms associated with substance use. Despite being rooted in and frequently associated with substance use, the principles and approaches of harm reduction are increasingly being used to mitigate harms associated with other public health issues—including mental health. Additionally, a person's chaotic use of substances may be contingent on the treatment of their mental health symptoms.

- **Family—Biological or Chosen.** People's biological or chosen families play crucial roles in both the provision and reception of RSS and HRS, when there is explicit permission given by the participant. Additionally, some of the most impactful work is being led by people with lived or living experience who are loved ones—including those of loss, those who love someone in recovery, and those who love a person (or people) who use drugs.
- **Harm Reduction isn't Defined as Drug Use, and Recovery isn't Defined as Abstinence.** Conflating '"drug use'" as harm reduction and '"abstinence'" as recovery is a common misconception and may contribute to discrimination. Harm reduction acknowledges the dangers associated with drug use, and simply seeks to mitigate risks by humanizing PWUD and equipping them with tools to stay safer and live healthier, self-directed lives. Similarly, many people practice complete abstinence within their pathway of recovery—and many do not. A person who identifies as being in recovery may also decide to be abstinent from one substance that they had a problematic relationship with but responsibly consume another substance that they never had a problematic relationship with.

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Appendix F—Resources

1. SAMHSA Harm Reduction Webpage
2. SAMHSA Recovery and Recovery Support Webpage
3. SAMHSA Overdose Response Toolkit
4. SAMHSA Harm Reduction Framework
5. National Harm Reduction Coalition (NHRC) Resource Center
6. Office of National Drug Control Policy, National Drug Control Strategy
7. SAMHSA's National Model Standards for Peer Support Certification
8. SAMHSA's Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS)
9. SAMHSA's Office of Recovery Webpage
10. SAMHSA's Working Definition of Recovery
11. What Are Peer Recovery Support Services? (SAMHSA)
12. Methods and Emerging Strategies to Engage People with Lived Experience (ASPE)
13. SAMHSA Programs to Advance Recovery Knowledge (SPARK) Technical Assistance Center
14. National Association of State and Territorial AIDS Directors (NASTAD) Technical Assistance
15. Faces and Voices of Recovery
16. Core Competencies for Peer Workers (SAMHSA)
17. Opioid Response Network Technical Assistance Center (ORN)
18. Comprehensive Opioid Stimulants and other Substance Use Program (COSSUP)
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